

# Patient Registration

Please circle: Dr. Mr. Mrs. Ms. Miss

Name: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Patient's Age: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Occupation: \_\_\_\_\_ Employer: \_\_\_\_\_

Home Phone: (\_\_\_\_) \_\_\_\_\_ Work Phone: (\_\_\_\_) \_\_\_\_\_

Email: \_\_\_\_\_ Cell Phone: (\_\_\_\_) \_\_\_\_\_

If married, spouse's name: \_\_\_\_\_

Spouse's employer: \_\_\_\_\_

Children living at your home:

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Name: \_\_\_\_\_ Age: \_\_\_\_\_

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Name: \_\_\_\_\_ Age: \_\_\_\_\_

If under 18 years old or parent's are financially responsible:

Father's Name: \_\_\_\_\_ Father's employer: \_\_\_\_\_

Mother's Name: \_\_\_\_\_ Mother's employer: \_\_\_\_\_

If you are a student, name of school or college: \_\_\_\_\_

Emergency contact: \_\_\_\_\_ Phone(\_\_\_\_) \_\_\_\_\_

Who may we thank for referring you? \_\_\_\_\_

Do you have any hobbies? \_\_\_\_\_

**General History**

Primary Care Physician: \_\_\_\_\_

Medications: \_\_\_\_\_

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Please circle those that apply to you:

- |                     |                          |                    |                            |
|---------------------|--------------------------|--------------------|----------------------------|
| High Blood Pressure | Thyroid Disease          | Pregnant           | Ear, nose, throat problems |
| Low Blood Pressure  | Neurological Disease     | Cigarette Smoker   | Chronic Fatigue            |
| Heart Problems      | Gastrointestinal Disease | Alcohol Abuse      | Chronic Pain               |
| Diabetes            | Musculoskeletal Disease  | Substance Abuse    | Weight Changes             |
| Respiratory Disease | Skin Disease             | Allergies          | Depression                 |
| Mental Disease      | Cancer                   | Sinus Problems     | Anxiety Disorder           |
| Immune Disease      | Migraine                 | Hay Fever          | Stroke                     |
| Endocrine Disease   | Other Headache           | Multiple Sclerosis | Urinary/Genital Disease    |

Other: \_\_\_\_\_

Allergies or sensitivities to medications: \_\_\_\_\_

**Family History**

Please circle those that apply:

- |                      |               |
|----------------------|---------------|
| Cataract             | Diabetes      |
| Glaucoma             | Heart Disease |
| Macular Degeneration | Stroke        |
| Retinal Detachment   | Other: _____  |

**Personal Eye Information**

Date of last eye exam: \_\_\_\_\_ Doctor's Name: \_\_\_\_\_

Please circle those that apply to you:

- |                            |                   |               |                   |
|----------------------------|-------------------|---------------|-------------------|
| Full time glasses wear     | LASIK surgery     | Glaucoma      | Eye injury        |
| Glasses wear only for near | Retinal surgery   | Cataract      | Spots/flashes     |
| Glasses wear only for far  | Cataract surgery  | Double vision | Light sensitivity |
| Soft contact lens wear     | Other eye surgery | Eye pain      | Itchy/burning     |
| Rigid contact lens wear    | Keratoconus       |               |                   |

Authorization:

I certify that I have read and answered the above information to the best of my ability. I authorize my insurance to pay directly to the doctor. I understand that my insurance may pay less than the actual bill for goods and services, and that I am responsible for the balance of those fees. My signature below serves as a signature on file for billing and that I have been given an opportunity to review the HIPAA Privacy Act as it applies to my care at Factoria Eye Clinic.

Signature of Patient: \_\_\_\_\_ Date: \_\_\_\_\_